PATIENT NAME: _____ DATE:_____

AUTHORIZATION AND GENERAL CONSENT

I hereby authorize Lisa A. Garner, M.D.,P.A or any physician designated by her/him, providing care to the above named patient to render such care including diagnostic procedures and medical treatment as they deem to be necessary or advisable in the diagnosis or treatment of this patient and I direct Lisa A. Garner, M.D.,P.A., or employees to follow her/his instructions and direction. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to results of treatments, tests or examination in this medical office.

GUARANTEE OF PAYMENT:

In consideration of the services to be provided to the patient, the undersigned promise(s) to pay Lisa A. Garner, M.D.,P.A, for services during the period of this examination, all amounts legally due and not paid by Medicare, or a third party payor, or other source on my behalf for services so rendered, which payment shall be due in full at the time of service. Additionally, I authorize and assign the DIRECT PAYMENT of any sum I owe by an insurance company obligated to reimburse me for the charges for your services or otherwise obligated to make payment to me based in whole or in part upon charges made for your services. In the event it is necessary to refer this account to a collection agency or an attorney, the undersigned further agrees to pay all reasonable cost of collection, including reasonable attorney fees. If more than one individual executes this agreement their liability shall be joint and several.

ASSIGNMENT OF BENEFIT, IF APPLICABLE:

In consideration for the services rendered or to be rendered, I hereby irrevocably assign and transfer to Lisa A. Garner, M.D.,P.A., all rights, title and interest to the benefits payable by any and all third party payors that are or may be liable for the services rendered, to the patient. This irrevocable assignment and transfer shall allow Lisa A. Garner, M.D.,P.A to pursue any such right of recovery. Even though I have made this assignment, I understand Lisa A. Garner, M.D.,P.A has the right to demand payment in full from me and the liability shall remain joint and several as between myself and all guarantors and third party payors, and I am responsible for payment for any charges not paid for me on my behalf.

MEDICARE ASSIGNMENT OF BENEFITS, IF APPLICABLE:

I hereby assign to Lisa A. Garner, M.D.,P.A. any Medicare or Medicaid benefits which may be available to pay for those services provided by Lisa A. Garner, M.D.,P.A. I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is true and correct.

AUTHORIZATION TO RELEASE INFORMATION, IF APPLICABLE:

The undersigned hereby authorizes Lisa A. Garner, M.D.,P.A., who have provided medical services during this examination to release information to: 1. The insurance company of record, 2. The Social Security Admin or its intermediaries, 3. 3rd party Payors

PERSONAL VALUABLES:

Lisa A. Garner, M.D.,P.A., does not accept any responsibility for money, articles of wearing apparel, jewelry, dentures, eyeglasses, hearing aids, or any valuables or belongings brought with any patient or patient's associates.

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HIPAA Acknowledgement of Receipt of Lisa A. Garner M.D.,P.A. Notice of Privacy Practices

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et seq., and regulations thereunder, as amended from time to time, collectively referred to as "HIPAA"and Patient Protection and Affordable Care Act of 2010 (ACA 2010) built on HIPAA 1996. Modification to the HIPAA Privacy, Security Enforcement, and Breach Notification Rules under the Health Information and Technology for Economic and Clinical Health Act and the Genetic Information Nondiscrimination Act; other Modifications to the HIPAA Rules. [Document 78 FR 5565, pages 5565-5702, 45 CFR 160, 45 CFR 164, RIN 0945-AA03, Document 2013-01073]

This authorization affects your rights in the privacy of your personal healthcare information. Please read it carefully before signing.

By signing this authorization you acknowledge and agree that Lisa A. Garner, M.D.,P.A., may use or disclose your Protected Health Information (PHI) for the purpose of providing treatment, for purposes relating to the payment of services rendered, and the Practice's general healthcare operations purposes.

For purposes of this consent, "Protected Health Information" means any information, including demographic information created or received by Lisa A. Garner, M.D., P.A. that relates to past, present, or future physical or mental health or condition.

Further, by signing this authorization you acknowledge that you have been provided a copy of and have read and understand Lisa A. Garner, M.D.,P.A's Privacy Notice containing a complete description of your rights, and the permitted uses and disclosures, under HIPAA. While Lisa A. Garner, M.D.,P.A. has reserved the right to change the terms of its Privacy Notice, copies of the Privacy Notice as amended are available and can be received by sending a written request with return address to the center where you were seen.

By signing below, you are acknowledging that you have been allowed to review, and understand this office's Notice of Privacy Practices of Lisa A. Garner, M.D.,P.A, which describes the Practice's policies and procedures regarding the use and disclosure of any of your Protected Health Information created, received or maintained by the Practice.

We may contact you by telephone, mail, or both to provide appointments, reminders, information about health reports and treatment alternatives. Messages will be left on answering machine/voice mail when available, unless otherwise instructed by you. We like to send acknowledgment to the person who referred you to the office.

In addition, I authorize Lisa A. Garner, M.D.,P.A. to release my personal health care information to the following person/people:

Name	Relationship
_____	_____
_____	_____

ACKNOWLEDGED AND AGREED TO BY:

PATIENT:

BY _____ **DATE _____**

Print Name_____

Or, ON BEHALF OF PATIENT

BY _____ **DATE_____**

Print Name _____

As _____